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ABSTRACT

A questionnaire designed to investigate physicians' knowledge of and experiences with child abuse, familiarity with New York State reporting laws, and characteristics of abusing families was sent to pediatricians and family practitioners in Monroe County, New York. The physicians were asked to estimate the number of child abuse cases that they saw and the number of child abuse cases that they reported in the last year (1978) and in the last five years (1974-1978). They were also asked to distinguish between cases of actual abuse (in which evidence of abuse was unquestionable) and cased of suspected abuse. Of these 170 physicians polled, 74 (43.5%) responded. Results indicated that physicians had both seen and reported roughly as many cased of suspected and actual child abuse in the last year as in each of the last five years. Also, the number of suspected cased generally exceeded the number of actual cases, and the number of cases reported was roughly 40% of the number of cases seen. About half of the physicians had had experience with abuse cases in the last year, and about three quarters of them had had such experience in the last five years. Other data are reported on the physicians' knowledge of the legal responsibilities in cases of child abuse, their training in the area of child abuse, their definitions of child abuse, and their beliefs regarding the characteristics of abusing families. (Author/SS)

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CHILD ABUSE: A Survey of Physicians' Attitudes and Practices

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There has been an increased awareness in the general public of the problem of child abuse and a growing concern among professionals in the helping services as to the causes of, prevention of, and intervention in cases of child abuse. A questionnaire designed to investigate physicians' knowledge of and experiences with child abuse, familiarity with New York State reporting laws, and characteristics of abusing families was sent to 170 physicians in Monroe County. Of the 170 physicians contacted, 81 were pediatricians and 89 were family practitioners.

Of those polled, 74 physicians, or 43.5%, responded. Forty-five percent of the physicians had offices located in the city of Rochester and 51% had offices located in suburban or rural areas. The remaining 4% had two offices, one in the city and one in a suburban or rural location. The pediatricians had been in practice an average of 16 years while the family practitioners had been in practice an average of 26 years.

Physicians were asked to estimate the number of child abuse cases that they saw and the number of child abuse cases that they reported in the last year and in the last five years. "Last

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year" was defined as the period from January 1, 1978 to January 1, 1979, and "the last five years" was defined as the period from January 1, 1974 to January 1, 1979. In addition, physicians were asked to distinguish between cases of actual abuse and cases of suspected abuse. Actual cases are those in which there is no question that abuse is involved, for example, evidence of sexual abuse in young children. Suspected cases are those in which the evidence is not clear-cut yet there is reasonable cause to believe that abuse has occurred.

Using the above definitions of actual and suspected child abuse, the data may be tabulated as shown on Table 1. Table 1 gives the yearly mean number of actual and suspected child abuse cases which were seen and reported during the one- and five-year periods. It is evident from the data that the means are statistically equivalent independent of the time frame. It seems that physicians have both seen and reported roughly as many cases of suspected and actual child abuse in the last year as in each of the last five years. Also, the number of suspected cases generally exceeds the number of actual cases. It is also evident, from Table 2, that the number of cases reported is roughly 40% of the number of cases seen. This suggests that if the physicians strictly adhered to the laws, a much greater number of cases would be reported.

To examine what fraction of the physicians have had involve-

ment with cases of child abuse, Table 3 was prepared. From that data it is apparent that roughly half of the physicians have had experience with abuse cases in the last year and about three quarters have had such experience in the last five years.

To understand the reactions of physicians when faced with potential child abuse cases, physicians were asked what they would do if they strongly suspected abuse. When confronted with such a case, 82% said they would report it, 8% said they would handle it in their own office, and 5% said they would wait until their suspicion was confirmed. One physician would only report medicaid patients. It seems that the majority of physicians are likely to report when confronted with unambiguous evidence of abuse.

Although physicians are mandated by law to report all cases of abuse or suspected abuse, it is clear that they do not. The questionnaire also investigated alternative resources utilized by physicians as referrals in cases of suspected and actual abuse. It was found that physicians were most likely to refer patients to a family service organization. The second most popular referral choice was to either a health clinic or Parents Anonymous. Thirty-nine percent of the respondents reported utilizing an alternative resource at least once.

Physicians have specific legal responsibilities in cases of child abuse. To probe their understanding of the law, physicians were asked three True-False items which tapped central issues.

The first item stated that "an 'abused child' refers to children under sixteen years of age." In actuality, the abuse law pertains to children under 18 years of age. The second item stated that "any physician who willfully fails to report a case of suspected child abuse or maltreatment is guilty of a misdemeanor", which is true. The final item stated that "if an oral report is made to the Department of Social Services, a written report must follow within 24 hours." By law, physicians have 48 hours, not 24, in which to make this report.

Thirty-six percent of the physicians recognized as false the statement that abused children refer to children under 16 years of age, and only 34% answered correctly the question concerning the time limit for filing a written report. Overall only 5 of the respondents, or 7.3%, correctly identified all three aspects of the reporting laws. However, 86% of the physicians knew the extent of the personal hazards, i.e., that failure to report is a misdemeanor.

That 64% of the physicians erroneously believe an "abused child" refers to children under 16 years of age may be related to the fact that the law was changed in 1977. On August 1 of that year, an amendment to the law went into effect which raised the age from 16 to 18 years. It appears that physicians were not adequately informed of the change. Neither are the majority of physicians aware that they have 48 hours in which to make a

written report. In fact, 66% thought they had less time than the law allows. Although misinformed, it appears that the majority would report immediately. Physicians are clearly aware of some aspects of the reporting laws, however, for example, the penalty for not reporting.

Information was collected concerning what training, if any, physicians received in the area of child abuse. The data were sorted into five categories. These categories were: little or no training; training during medical school, internship, and/or residency; continuing education; reading; and personal experience. These categories are overlapping, for example, a physician may have reported training during residency as well as training through continuing education. Of the respondents, 71% received little or no formal training. Continuing education was reported by 15% of the respondents, 13% cited reading, and 11% cited personal experience. Only 29% of the respondents received training during medical school, internship, and/or residency. Physicians were also asked where they obtained information about child abuse. The four most frequently cited categories were as follows: medical journals, 83.3%; lectures, 44.4%; meetings, 37.5%; and colleagues, 34.7%. It would appear then, that although 71% of the physicians received little or no formal training, most are aware of the problem of child abuse and try to keep informed, particularly through reading medical journals. It seems that there

is a need for a community resource center which could serve to disseminate information about child abuse and maltreatment to physicians and other interested professionals.

Physicians were in addition asked to provide a definition of child abuse. The responses were divided into four categories. These categories were: "occult trauma", "emphasis on perpetrator", "emphasis on injury", and "discipline not appropriate". The responses were categorized as "occult trauma" if it was stated that abuse entailed an injury that was not adequately explained or accounted for by the caregiver. The "emphasis on perpetrator" category contained items which emphasized the role of the abuser. In these cases the injury was described as being the result of "unintentional overreaction", "mental illness", or "impulsive" or "willful" acts. Respondents in the "emphasis on injury" category focused strictly on the physical damage resulting from abuse. Examples of such responses were either lists of the types of injuries found, such as fractures, lacerations and bruises, or statements like "bodily assault", or "physical trauma". For the "discipline not appropriate" category, typical responses were "unnecessary punishment", or "(an) unhealthful outcome which was...preventable by usual child care activities " Thirteen percent of the physicians gave "occult trauma" definitions, 37% gave "emphasis on perpetrator" definitions, 34% gave "emphasis on injury" definitions, and 16% gave "discipline not appropriate" definitions. Reasonably enough, it seems that physicians suspect abuse on the basis of the likelihood

that the cause of injury is other than accidental--the injury is severe and either "willfully" or inappropriately inflicted.

Given the above definitions of abuse, it is interesting to note what circumstances are actually required to elicit reporting. Physicians were asked to supply a brief description of the circumstances surrounding their last reported case. The responses were placed into four categories. These categories were: "referrals", "informed by family member", "physical abuse", and "neglect". An example from the "referrals" category would be a case which was brought to the attention of a physician by a third party who was not a family member, for example a school nurse or a neighbor. The "informed by family member" category included cases in which a parent admitted lying about the cause of an injury, or a parent revealed that a spouse or another person injured the child. It should be noted that if a child is found to be severely injured by a nonfamily member, for example a baby-sitter, the parents are legally liable. Examples from the "physical abuse" category are statements like "ten broken bones", or "physical findings". The "neglect" category contained items like "malnourished infant with developmental delay", or "child brought to office by sitter stating mother had not returned in 6 days." Nine percent of the responses were in the "referral" category, 20% in the "informed by family member" category, 54% in the "physical abuse" category and 17% in the "neglect" category. It is interesting to note that one-fifth of the cases were reported because the caregiver disclosed

information to the physician regarding abusive behavior. It is not known if, and to what extent, physicians probed for this information. The tentative conclusion from this data is that physicians tend to heavily rely on physical evidence of abuse when deciding to report.

The data were further broken down by type of injury. Thirty-five percent of the respondents did not specify the type of trauma involved. The remaining responses revealed that 19% of the cases involved burns, 15% each involved fractures and bruises, 8% involved sexual abuse, 4% involved whipping and 4% involved poisoning.

Items concerning physical signs of abuse were included in the questionnaire in an attempt to discover what kinds of injuries or circumstances surrounding injuries physicians might believe are caused by abusive behavior. Immersion burns were taken to be good indicators of abuse as were instances of multiple injuries that were not brought to the attention of a physician for a prolonged period. There are, then, identifiable conditions and/or situations which lead physicians to suspect abuse. It would be interesting to discover additional circumstances or clusters of circumstances which influence a physician's decision to report, or at least suspect abuse.

Also employed were items designed to study physicians' responses to generalizations about characteristics of abusing families. There was high agreement that abused children are

likely to become abusing parents, that child abusers have unrealistic expectations of their children, and that child abuse is likely if the observed injury and the parent's explanations are discrepant. Physicians did not agree that single parents are more abusive than parents from a two-parent home. Nor did they agree that parents who abuse their children do not love them, or that the incidence of abuse is highest in low income families. It appears then, that physicians are aware of some of the myths surrounding the area of child abuse and would not be inclined to believe that single parents and low income families are prone to abusive behavior. Presumably, they would be better able to recognize child abuse as such when confronted with it in situations in which the family is neither poor nor run by a single parent.

In summary, it appears that physicians report about 40% of the cases of actual and suspected child abuse that they see. They do not ignore the problem, however, but seem to utilize a wide array of other resources, predominantly family service organizations, health clinics and Parents Anonymous. Thirty-nine percent of the physicians have utilized an alternative resource at least once. Unfortunately it is not known whether physicians attempt follow-up or simply make a referral and then drop the issue. A referral without follow-up may be inadequate.

The most significant finding is that physicians are misin-

formed regarding the specifics of the reporting laws. Section 421 of the Social Services Law mandates that it is the responsibility of the Department of Social Services to educate and train those persons who are required by law to report. Apparently physicians have not been adequately informed as to their obligations.

Another problem discovered in this questionnaire is that 71% of the physicians received little or no formal training in the area of child abuse. It was found that the majority of physicians try to keep informed, especially through reading. It seems, however, that medical schools and community organizations and agencies could take a more active part in the education of pediatricians and family practitioners in this area, rather than leaving it to self-motivation.

Other interesting findings concerned physicians' beliefs about certain physical signs being predictive of abuse, and their beliefs about characteristics of abusing families. It was discovered that immersion burns and multiple injuries which are not treated for prolonged periods are considered to be good indicators of abuse. Another good indicator of abuse is the occurance of a discrepancy between the physician's observations and the parent's explanation of the cause of an injury.

Physicians do not believe that the incidence of abuse is related to income, marital status, or that the parents do not

love their children. Physicians do believe that abused children become abusive parents and that abusers have unrealistic expectations of their children.

In conclusion, it seems that physicians are concerned about child abuse and try to deal with the problem in a variety of ways. What remains to be answered is why physicians do not report more cases, and how the cases which they do not report are handled. Reporting is not the only solution leading to adequate treatment of cases of child abuse and maltreatment.

Table 1. Mean number of cases seen and reported per physician (raw data).

	1 Year		5 Years	
	Seen	Reported	Seen Per Year	Reported Per Year
Actual Child Abuse	1.1	0.4	0.9	0.3
Suspected Child Abuse	1.6	0.5	1.1	0.3

Table 2. Percentage of cases seen which were reported.

	1 Year	5 Years
Actual Child Abuse	43	37
Suspected Child Abuse	35	37

Table 3. Number of physicians who saw or reported at least one case of abuse. Values shown in parentheses reflect the total number of responses to each particular question.

	1 Year		5 Years	
	Seen	Reported	Seen	Reported
Actual Child Abuse	28 (66)	17 (64)	48 (60)	34 (60)
Suspected Child Abuse	31 (62)	15 (63)	44 (58)	23 (59)
Actual and/or Suspected	35 (68)	20 (66)	51 (65)	35 (63)